Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $13,140.00 for dates of service 08/14/01 through 10/22/01.
   b. The request was received on 03/11/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/19/02
   b. HCFA(s)
   c. TWCC 62 forms
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. HCFA(s)
   c. EOB
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/26/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 04/29/02. The response from the insurance carrier was received in the Division on 03/22/02. Based on 133.307 (i) the insurance carrier's response is timely.

III. PARTIES' POSITIONS

1. Requestor:

   a. "I am disputing the following bills, which consist of Chronic Pain Mgmt sessions from DOS 8/14/01 – 10/22/01. According to the Insurance carrier, reimbursement was made as fair and reasonable. However research has revealed that other carriers have paid more than (Carrier) alleged fair and reasonable. Chronic Pain Sessions as outlined on pg. 40/41 consist of a "multidisciplinary, individualized,

and intensive treatment" to deal with the complex nature of medical and mental problems associated with chronic disability…It is unreasonable to expect reimbursement for such treatment to fall within the payment range the carrier has chosen. Our documentation clearly substantiates the level of service billed. We billed $175.00 an hour and (Carrier) recommended $80.00 an hour. With the CARF reduction we should have been paid $140.00 an hour, therefore I am requesting that the remainder $60.00 an hour be reimbursed."

2. Respondent:

a. "Respondent's Position: Carrier believes $100.00 per session is fair and reasonable. Since the facility is not CARF accredited, reimbursement is made at 80% of fair and reasonable. No evidence to substantiate charge of $175.00 per session."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 08/14/01 extending through 12/22/01.

2. The carrier's EOB denial submitted is "F-THIS PROCEDURE CODE IS REIMBURSED BASED ON THE MEDICAL FEE SCHEDULE. IF ONE IS NOT MANDATED, THE UCR ALLOWANCE IS REIMBURSED FOR THE ZIP CODE AREA."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:

08/14/01	97799-CP-AP	$1,050.00 (6.0 units)	$480.00	F	DOP $175.00 (per hour)	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i) & 133.305 (i) MFG;MGR (II)(C)(G) MFG GI (III)(A)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011 (d). The provider is a non- CARF accredited facility. The provider billed in accordance with the referenced Rule and medical documentation indicates that the services were rendered. Regardless of the carrier's lack of methodology and response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. The carrier has not submitted any evidence or methodology it used to determine fair and reasonable reimbursement. In light of recent SOAH decisions, where providers have submitted EOBs for fair and reasonable, SOAH has placed minimal value on EOBs for documenting fair and reasonable. The willingness of some carriers to reimburse at or near the billed amount does not necessarily indicate that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011 (d) of the Texas Labor Code. Therefore, additional reimbursement is not recommended.
08/15/01		$1,050.00 (6.0 units)	$480.00	F			
08/16/01		$1,050.00 (6.0 units)	$540.00	F			
08/17/01		$1,050.00 (6.0 units)	$660.00	F			
08/20/01		$1,050.00 (6.0 units)	$480.00	F			
08/21/01		$1,050.00 (6.0 units)	$480.00	F			
08/22/01		$1,050.00 (6.5 units)	$480.00	F			
08/23/01		$1,050.00 (6.0 units)	$480.00	F			
08/28/01		$1,050.00 (6.0 units)	$480.00	F			
08/29/01		$1,050.00 (6.0 units)	$480.00	F			
08/30/01		$1,050.00 (6.0 units)	$480.00	F			
08/31/01		$1,050.00 (6.0 units)	$480.00	F			
09/10/01		$1,050.00 (6.0 units)	$480.00	F			
09/13/01		$1,050.00 (6.0 units)	$480.00	F			
09/14/01		$1,050.00 (6.0 units)	$480.00	F			
09/17/01		$1,050.00 (6.0 units)	$480.00	F			
09/18/01		$1,050.00 (6.5 units)	$480.00	F			
09/19/01		$1,050.00 (6.0 units)	$480.00	F			
09/20/01		$1,050.00 (6.0 units)	$480.00	F			
09/21/01		$1,050.00 (6.0 units)	$320.00	F			
09/25/01		$1,050.00 (6.0 units)	$400.00	F			
09/26/01		$1,050.00 (6.0 units)	$320.00	F			
09/28/01		$1,050.00 (6.0 units)	$480.00	F			
10/01/01		$1,050.00 (6.0 units)	$480.00	F			
10/02/01		$1,050.00 (6.0 units)	$480.00	F			
10/03/01		$1,050.00 (6.0 units)	$480.00	F			
10/04/01		$1,050.00 (6.5 units)	$480.00	F			
10/05/01		$1,050.00 (6.0 units)	$480.00	F			
10/08/01		$1,050.00 (6.0 units)	$480.00	F			
10/09/01		$1,050.00 (6.0 units)	$480.00	F			
10/10/01		$1,050.00 (6.0 units)	$480.00	F			
10/11/01		$1,050.00 (6.0 units)	$480.00	F			
10/12/01		$1,050.00 (6.0 units)	$480.00	F			
10/16/01		$1,050.00 (6.0 units)	$480.00	F			
10/17/01		$1,050.00 (6.0 units)	$480.00	F			
10/18/01		$1,050.00 (6.0 units)	$480.00	F			
10/19/01		$1,050.00 (6.5 units)	$480.00	F			
10/22/01		$1,050.00 (6.0 units)	$480.00	F			

Totals	$39,025.00	$18,080.00		The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 9th day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.